DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445286	A. BUILDING _____ B. WING _____	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION- FAIRPARK	307 N FIFTH ST BOX 5477 MARYVILLE, TN 37801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED Statement of Deficiencies An annual Recertification and Complaint survey #31201 were completed at Kindred Nursing and Rehabilitation Fairpark, April 22 through April 25, 2013, with an extended survey completed on April 25, 2013. Based on survey findings, the facility was cited Immediate Jeopardy for F224, due to a resident elopement February 2, 2013. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Corporate Consultant were notified of the Immediate Jeopardy on April 24, 2013, at 5:25 p.m., in the Administrator's office. Substandard Quality of Care was cited under tag F224 at a scope and severity level of "J". The Immediate Jeopardy was effective February 2, 2013, through February 4, 2013, and was removed February 5, 2013. A corrective action plan (Allegation of Compliance) which removed the immediacy of the jeopardy, was received and corrective actions were validated onsite by the surveyor team on April 24-25, 2013. Non-compliance continues at a "D" level for F224. The facility is required to submit a Plan of Correction.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna D. Hammontree | TITLE: Executive Director | (X5) DATE: 5/13/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide privacy and confidentiality for personal and clinical records of the residents on one (100 hall) of two halls. The findings included: Observation of 100 hall on April 22, 2013, at 5:20	F 164	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F164 It is the practice of this facility to ensure the resident of his/her right to personal privacy and confidentiality of his/her personal and clinical records. The note book binders containing the ADL records were removed from the corridor and placed in the nurses' station. An audit was conducted to ensure that no other resident documentation was in an inappropriate location. The DNS and SDC instructed the nursing staff, licensed and C.N.A. on the importance of maintaining confidentially and privacy of resident information. Additional in-services for staff will be conducted on 5/6, 5/10 and 5/12. Education on HIPPA requirements to include confidentiality and privacy of residents health related information is included in orientation for all new hires. The DNS/SDC/RN Supervisors will monitor for compliance each shift at least 5 days a week X 4 weeks, then 3 days a week X 4 weeks and then at least weekly there after. The DNS will report results of the rounds/audits to the Facility Performance Committee at it monthly meeting for review, discussion and recommendation.	5/18/2013

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F 164	Continued From page 2 a.m., during the initial tour of the facility revealed three notebook binders containing Activity of Daily Living (ADL) records with resident information sitting in the hand rail outside of room 104. The first book contained information about residents in room 100 through room 104, the second book contained information about residents in room 105a through 109b and the third book contained information about residents in room 110a through 115b. The information contained in the books included the resident name, room number, date of birth, Medical Doctor's (MD) name, medical record number, and information about the residents care. Interview with Certified Nursing Assistant (CNA) #4 on April 22, 2013, at 5:30 a.m., in the hallway next to room 104, confirmed the ADL records were placed in the hallway and were not kept private and confidential.	F 164	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documentation, review of facility policy, and interview, the facility failed to provide supervision to prevent neglect of a cognitively	F 224	F224 The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of residents' property. Resident #99 upon return to facility on 2/2/2013 had a wander guard device placed on the ankle. LN observed and documented presence of device every shift and continue such until discharge home on 2/23/13. Additional interventions for Resident #99 included one to one observations of the resident for forty-eight hours, the staff observations and documentation of the residents' status every fifteen minutes until the resident was discharged on Feb.23, 2013.	5/18/2013

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F 224	Continued From page 3 impaired resident (#99), resulting in an elopement, of six residents reviewed. The facility's failure to prevent neglect and elopement for resident #99 resulted in Immediate Jeopardy to resident #99 (Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.) The Administrator and Corporate Consultant were notified of the Immediate Jeopardy on April 24, 2013, at 5:25 p.m., in the Administrator's office. The Immediate Jeopardy was effective February 2, 2013, through February 4, 2013, and was removed February 5, 2013. A corrective action plan (Allegation of Compliance) which removed the immediacy of the jeopardy, was received and corrective actions were validated onsite by the surveyor team on April 24-25, 2013. Non-compliance continues at a "D" level for F224. The facility is required to submit a Plan of Correction. The findings included: Resident #99 was admitted to the facility on January 31, 2013, with diagnoses including Hypertension, Hyperlipidemia, Muscle Weakness, Dysphagia, Symbolic Dysfunction, and Dementia. Medical record review of the Patient Nursing Evaluation dated January 31, 2013, revealed, "...1. Patient currently wanders and/or has a history of wandering...Mental Health...Behaviors: wandering...Mood:	F 224	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Audit of all in-house residents was conducted by members of the Interdisciplinary Team to ensure each resident had been assessed for potential for elopement. On residents identified at risk for elopement an audit was conducted to validate risk assessments were current and accurate. Care plans were also reviewed on at risk residents and updated if needed. Medication Administration Records were audited (for all residents) for current photographs of each residents and existing resident photographs were updated as needed. Nursing assistant's assignment sheets were reviewed and updated for residents at risk for elopement. Facility staff was in-serviced by SDC on what behaviors/actions that patients may exhibit that could indicate a risk of elopement and instructed to report any of the signs to the licensed nurse or other clinical staff immediately. Licensed nurses were also in-serviced by the SDC on the P&P to follow when admitting a resident to assess for the risk of elopement and to document, initiate and implement appropriate care plan interventions. These in-services were conducted on 2/2, 2/3 and 2/4/13. Elopement at Risk Notebooks containing photographs and physical descriptions of	

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F 224	Continued From page 4 worried...agitated...restless...Ambulation...Independent...Transfer... Independent...Dressing...Independent...Functional Impairment of Range of Motion...Upper extremity...no impairment...Lower Extremity...no impairment..." Further review of the evaluation revealed the resident scored a 6 on the Nursing Delirium Screening Scale (NuDESC) "...a score of greater than 2 on NuDESC identifies presence of delirium. Add interventions to care plan..." Medical record review of the Wander/Elopement Risk Evaluation dated January 31, 2013, revealed, "...1. Resident is at risk for Wandering: yes...Resident is at risk for Elopement: yes..." Medical record review of the Interim Plan of Care dated January 31, 2013, revealed, "...Other Information...Elopement Risk...Wanderguard (device placed on the ankle of a resident to alert staff of a resident's presence in an unauthorized area) in place..." Medical record review of the Resident Progress Notes dated February 2, 2013, at 8:00 a.m., revealed, "...(resident) came out of room in the middle of the NOC (night). Some restless behavior noted. Confusion over where (resident's) bedroom and bed were..." Medical record review of the Resident Progress Notes dated February 2, 2013, at 10:30 a.m., revealed, "...resident awake, alert, confused @ (at) times...resident opened dirty linen closet backing up as if it were (resident's) toilet, redirected to resident's bathroom..." Medical record review of the Resident Progress	F 224	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* patients determined at risk for elopement are maintained at the nursing station and front lobby desk area. New admissions assessed at risk for elopement will have information added to the notebook within 24 hrs of admission. Security guard on duty at time of event was counseled and re-educated by his supervisor on his duties including ensuring individuals leaving facility signed out before leaving .. Security guards in-serviced by the facility administrator on the location and use of the Elopement at Risk Notebook as well as general abuse P&P. Facility maintains a supply of wander guard devices, straps and snaps at the nurse station. Additional supplies will be maintained in the Central Supply Room. The Administrator or her designee monitors the equipment drawer at least 5 days a week for availability and proper functioning of the safety equipment to include sufficient supplies if needed, for weekends and holidays. The DNS or designee will monitor new admissions during daily weekday clinical rounds to validate that the elopement risk assessment has been completed, and care plans are in place. And the elopement notebook has been updated. Medical Records or designee will perform a	

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F 224	Continued From page 5 Notes dated February 2, 2013, at 12:10 p.m., revealed, "...Friend of resident came to visit. Unable to locate resident in dining area. Staff members then started to look for patient. Executive Director notified, (police department) notified...Physician here and informed...parking area and grounds checked..." Medical record review of the Resident Progress Notes dated February 2, 2013, at 1:37 p.m., revealed, "...Executive Director located resident at (resident's) house..." Review of facility documentation of a witness statement from Licensed Practical Nurse (LPN) #1 dated February 2, 2013, revealed, "...This nurse observed resident...in the service hall looking for the bathroom..." Review of facility documentation of a witness statement from Dietary Aide #1, not dated, revealed, "...saw (resident) in the service hall around 8:30 a.m...went and got a nurse and I stayed in service hall...nurse came and got (resident)..." Review of facility documentation of a witness statement from Registered Nurse (RN) #2 dated February 4, 2013, revealed, "(On February 2, 2013)...staff reported that patient was wandering service hallway...0800 (8:00 a.m.) during breakfast...Assisted patient to room. Pt (patient) stated that (resident) was trying to find bathroom...@ 1015 (10:15 a.m.) Certified Nurse Aide (CNA) reported pt tried to enter closet, thought it was bathroom. Patient was assisted to bathroom and walked to lobby and sat on sofa in front of nurse station...(resident's physician)	F 224	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* weekly audit of all new admissions medical records to ensure that elopement risk assessment is completed. Care plan with intervention in place, C.N.A. assignment sheets updated and notebook updated timely. The Administrator bring the results of these audits to the Facility Performance Committee at its monthly meeting for review, discussion and recommendation. The Committee met on March 28, 2013 and April 15, 2013 and the systems established continue in place and are effective. The Facility Performance Committee met on May 17, 2013 to review and discuss the survey results and to develop and implement corrective action.	

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F 224	Continued From page 6 notified of pt's confusion...Around 1115 (11:15 a.m.) patient was assessed by (resident's physician)..." Review of facility documentation of a witness statement from CNA #3 dated February 2, 2013, revealed, "...Saturday February 2nd 2013, around 10:30 a.m., I noticed (resident) had gotten confused and tried to use the linen closet as a restroom...at 11:20 a.m...went to (resident's) room and (resident) was not there...I proceeded to look in other rooms. Then the entire nursing staff started looking everywhere for (resident)..." Review of facility documentation of a witness statement from an interview with a resident conducted by the Master Social Worker, dated February 6, 2013, revealed, "...I didn't think (resident would) get out with that security guard up there..." Review of the facility policy Elopement Risk Evaluation...Policy: Accidents and Supervision to Prevent Accidents, dated April 28, 2011, and provided by the facility revealed, "...Update and/or implement care plan interventions for reducing and/or preventing attempts of elopement, examples of interventions may include, but are not limited to: a. Wandering Prevention System..." Interview with RN #3 on April 24, 2013, at 4:08 p.m., in the Dining Room, confirmed the RN had been the supervising nurse at the time of the resident's admission to the facility, and confirmed the resident was assessed as an elopement risk on the resident's admission January 31, 2013. Continued interview with the RN revealed the RN had attempted to locate a Wanderguard	F 224		

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F 224	Continued From page 10 out log for all visitors entering or exiting the facility. 12. Licensed Nurses who complete admission Patient Nursing Evaluations were re-educated on policies and procedures for completing care plans and initiating interventions when residents were deemed potential elopement risk. Interviews with two Registered Nurses, three Licensed Practical Nurses, six Certified Nursing Assistants, and one Security Guard on April 25, 2013, confirmed all had received education and were able to verbalize the facility's policy and procedure for residents at risk for elopement. C/O #31201	F 224	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility record review, and interview, the facility failed to provide notification of a new roommate for one resident (#87) of seven Stage I residents interviewed. The findings included: Resident #87 was admitted March 19, 2012, with diagnoses including Vascular Dementia, Depression, Diabetes Mellitus Type II, Hypopotassemia, Hypertension, Glaucoma, Labyrinthitis, and Diabetic Neuropathy.	F 247	F247 It is the practice of the facility to ensure the resident receives notices the resident's room or roommate is changed. Resident #87 will be informed in advance of any new roommate and /or room change by the facility SSW and documented in the resident's medical record. Every resident residing in the facility will be informed in advance when receiving a new roommate and or room change by the facility SSW. In the absence of the SSW, DNS or the charge nurse will perform this function The DNS, SDC or SSW will in service all clinical staff including Licensed nurses on resident's right to advance notice of roommate or room change. In-services will	5/18/2013

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F 247	Continued From page 11 During a resident interview on April 22, 2013, at 8:30 a.m., in the resident's room, the resident stated the first roommate had passed (expired) and no one notified (the resident) of the new roommate coming. Medical record review of the Resident Progress Notes dated December 31, 2012 to January 31, 2013, revealed no documentation of notification of a new roommate for the resident prior to the new roommate's arrival. Review of facility admission records and interview on April 24, 2013, at 1:45 p.m., with the Admissions Coordinator, in the admissions office, confirmed the resident's original roommate had passed away; a new roommate was admitted and assigned to the resident's room January 22, 2013; and no notification of a new roommate was given to the resident.	F 247	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* be conducted on 5/13, 5/14, and 5/15/13 Medical records clerk or SSW will audit medical records of residents who received a new roommate or room change each week for the previous week X 4 weeks and then monthly X 3 months and then a 10% sample of room changes /roommate changes each quarter. The medical records clerk will submit written reports of these audits to the facility administrator. The Administrator will report results of the audits to the Facility Performance Improvement Committee (QAA) at it regular scheduled meeting for review, discussion and recommendations, if any.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	F280 It is the practice of this facility to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment, to review and revised after each assessment and with a change in condition/status of a resident by a team of qualified persons. The care plan of resident #8 has been updated to reflect change in Advance Directives. The care plan of resident #17 reviewed to ensure safety device interventions are current and remain applicable. The care plan of resident #102 was updated with interventions addressing	5/18/2013

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F 280	Continued From page 12 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update a care plan for code status (Advance Directives for care in case of death) for one (#8); for interventions to prevent falls for one (#17); and for interventions for active infections for one (#102) of thirty-four sampled residents. The findings included: Resident #8 was admitted to the facility on September 20, 2012, with diagnoses including Chronic Obstructive Pulmonary Disease, Epilepsy, Hypertension, Osteoporosis and Muscle Weakness. Medical record review revealed the resident had been admitted to the hospital on January 30, 2013, for Dysphagia (difficulty swallowing) with Aspiration Pneumonia, and returned to the facility on February 15, 2013. Medical record review of a physician's order dated March 25, 2013, revealed, "DNR (Do Not Resuscitate)/Comfort Care." Medical record review of the Resident's Comprehensive Care Plan dated March 4, 2013,	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Interdisciplinary team comprised of nursing, dietary, social services and activities will audit all care plans on residents' with an advanced directive for accurate & current information, audit all care plans on residents with history of falls last 30 days and/ or at risk for falls for appropriate fall prevention interventions and also the care plans of each resident with an active infection for all appropriate interventions. During the weekday daily clinical rounds (DNS/SDC/ MDS nurses/ RN supervisor SSW, Activities Director) will review the 24 hour nursing report, lab reports, physician orders, admission/re-admission assessments, and evaluations for any changes of status/condition that would warrant a revision/update of the residents' care plan. The care plan will then be reviewed for appropriate intervention(s) and related documentation and communication. The DNS, SDC and/or Care Plan Coordinator will in-service licensed staff on process to review, revise and/or update a comprehensive care plan, with the related documentation and communication on 5/13, 5/14 and 5/15/13. The DNS or designee will audit 25% of the medical records with an identified change to include but not limited to changes in	

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	445286	A. BUILDING _____ B. WING _____	04/25/2013

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F 280	Continued From page 13 revealed, "Advance Directive Guidelines" with interventions of CPR and transport to hospital when indicated, and had not been updated to reflect the physician's orders on March 25, 2013, for DNR/Comfort Care. Interview with the Care Plan Coordinator, in the conference room, on April 24, 2013, at 9:00 a.m., confirmed the care plan had not been updated to reflect the DNR /Comfort Care Only physician's order dated March 25, 2013. Resident #17 was admitted to the facility on October 31, 2009, with diagnoses including Alzheimer's Disease, Dementia with Behavior Disturbance, Generalized Anxiety Disorder, Constipation, Stomach Function Disorder, Generalized Pain, Depressive Disorder, Psychosis, Personal History of Fall, Late Effect Cerebral Vascular Disease. Medical record review of the Quarterly Minimum Data Set (MDS) dated January 18, 2013, revealed the resident was severely cognitively impaired, required extensive assistance will all activities of daily living (ADLs), and was only able to stabilize with human assistance during transfers and walking. Medical record review of the resident's care plan revealed the resident was at risk for falls. Continued review of the resident's care plan revealed a "...personal alarm installed..." as an update to the care plan on September 20, 2012, and "...sensory bed pad alarm..." was added as an update on September 21, 2012. Medical record review of Post Fall Evaluation	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* interventions addressing advance directives, active infections, and fall prevention 5 days a week X 4 weeks, then 2 X a week X 4 weeks, then weekly X 4 weeks and then at least 20% of the effected medical records monthly. The DNS or designee will report results of the audits to the Facility Performance Committee at it monthly meeting for review, discussion and recommendation if indicated monthly X one quarter and then at least quarterly thereafter.	

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F 280	Continued From page 15 Medical record review of a Resident Progress Note with a Condition Change Form attached dated March 8, 2013, revealed, "...pt (patient) is having yellow color drainage from...eyes..." Medical record review of a Resident Progress Note with a Condition Change Form attached dated April 20, 2013, revealed, "...pt has drainage from both eyes drainage is dark green..." Medical record review of the Comprehensive Care Plan dated March 4, 2013, revealed no revision to the plan of care for the eye infection. Interview with the Minimum Data Set (MDS) Coordinator on April 24, 2013, at 8:10 a.m., in the MDS Coordinator's office, confirmed the care plan for resident #102 had not been revised or updated with interventions for the MRSA infection.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide interventions for constipation in a timely manner for one resident (#14) of thirty-four residents reviewed.	F 309	F309 It is the practice of this facility to ensure each resident receives the necessary care and services to attain, or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #14 remains on an effective bowel maintenance program that has resulted in regular bowel movement pattern for at least the last 60days. The DNS/SDC/MDS nurses and / charge nurses will audit the flow sheets/ BM records as well as the physician orders and medication records for all residents for a) documentation of a pattern of regular bowel movements b) physician orders for the bowel protocol that includes residents on scheduled pain medication c) administration of the	5/18/2013

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F 309	Continued From page 16 The findings included: Resident #14 was admitted to the facility on December 12, 2012, with diagnoses including Alzheimer's, Dementia, Muscle Weakness General, Viral Pneumonia, and Dysphagia. Medical record review of the Admission Minimum Data Set dated December 19, 2012, revealed the resident was incontinent of bowel, was totally dependent on staff for activities of daily living, and was cognitively impaired. Medical record review of the Activities of Daily Living (ADL) Flow Record for December 2012, revealed documentation the resident did not have a bowel movement between December 13 and December 27, 2012 (13 days). Medical record review of the Care Plan dated December 26, 2012, revealed, "...At risk for constipation...Maintain comfortable and regular bowel movements at least every 3 days...Administer medications per physician order & (and) monitor effectiveness...Monitor for and report any S&S (signs and symptoms) constipation such as abdominal cramping, diarrhea, N/V (nausea and vomiting), no BM (bowel movement) for 3 days..." Medical record review revealed a Change in Condition form dated December 27, 2012, "0 (zero) BM x (times) 11 days." Further medical record review revealed physician orders dated December 27, 2012, for a dulcolax suppository and tap water enemas until clear. Medical record review of a nursing note dated	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* bowel protocol by the licensed. The DNS/SDC will in-service nursing staff both licensed nurses and nursing assistants, on the facility bowel protocol to include not limited to monitoring, reporting and documenting of BMs, timely administering of the bowel program protocols on 5/13, 5/14 and 5/15/13. The evening shift charge nurses will review the ADL flow records each day for BM documentation and initiate the facility's physician Bowel Protocol if no BM after 3 days. During the weekday daily clinical rounds the DNS/ADNS/SDC/ MDS nurses or RN supervisor will review the ADL flow sheet for documentation of BMs, evidence of a consistent regular pattern or initiation of the bowel protocol if indicated. The DNS or designee will audit 25% of the ADL Flow Records for BM documentation and intervention if indicated with an 5 days a week X 4 weeks, then 2 X a week X 4 weeks, then weekly X 4 weeks and then at least 10% of the ADL Flow Records weekly thereafter. The DNS or designee will report results of the audits to the Facility Performance Committee at it monthly meeting for review, discussion and recommendation if indicated monthly X one quarter and then at least	

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F 309	Continued From page 17 December 27, 2012, and the Treatment Record for December 2012, revealed the resident was given a Dulcolax suppository and a Fleets enema. Further review of the nursing note revealed the nurse digitally removed (used a finger-to manually remove) "firm stool" from the rectum. Interview and medical record review with Registered Nurse (RN) #1 on April 25, 2013, at 10:00 a.m., in the nurse's station, confirmed the resident did not have a bowel movement from December 13 through December 26, 2012. Continued interview confirmed facility nursing procedures were for any resident who had not had a bowel movement in three days, nursing was to contact the physician to obtain an order for Milk of Magnesia and enemas if Milk of Magnesia was not successful in producing a bowel movement. Continued interview confirmed the resident was on "pain" medication, which increased the resident's risk for constipation. Continued interview and medical record review confirmed the RN had to manually remove "very firm" stool from the resident's rectum because the resident had constipation and was unable to pass the stool independently and interventions for constipation had not been implemented timely.	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* quarterly thereafter.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 It is the practice of this facility to ensure the residents' environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. Resident #17 interventions to reduce risk of falls has been reviewed and revised by the interdisciplinary team and bed bolsters for	5/18/2013

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F 323	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documentation, and interview, the facility failed to ensure safety devices were in place and functioning to prevent falls for one resident (#17) of thirty-four residents reviewed. The facility's failure to ensure safety devices were in place and functioning resulted in harm to resident #17. The findings included: Resident #17 was admitted to the facility on October 31, 2009, with diagnoses including Alzheimer's Disease, Dementia with Behavior Disturbance, Generalized Anxiety Disorder, Constipation, Stomach Function Disorder, Generalized Pain, Depressive Disorder, Psychosis, Personal History of Fall, Late Effect Cerebral Vascular Disease. Medical record review of the Quarterly Minimum Data Set (MDS) dated January 18, 2013, revealed the resident scored 4 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was severely cognitively impaired; required extensive assistance will all activities of daily living (ADLs); and was only able to stabilize with human assistance during transfers and walking. Medical record review of the resident's care plan revealed the resident was at risk for falls. Continued review of the resident's care plan revealed a "...personal alarm installed..." as an update to the care plan on September 20, 2012,	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* left and right side of bed/mattress were added, are in place and working. The DNS/ADNS/SDC/MDS nurses conducted an initial audit all residents who are utilizing a safety device as a fall prevention/intervention measure to ensure it is the appropriate device, it is in place and it is functioning properly. As a result of the audit seven residents identified as no longer requiring the use of an alarm safety device. Twenty residents with fall intervention / prevention alarm safety devices were reviewed. The review included the type of device in use and when/where to use with appropriate clarifications which included tab alarm, pressure pad alarm, to either bed or chair or both, positioning chair cushions, etc. Care Plans and nursing assistant assignment sheets were revised and or updated based upon this audit by the interdisciplinary team and communicated to the nursing staff. The interdisciplinary care plan team routinely reviews residents with safety devices at least quarterly and with significant change, also during the weekday daily clinical rounds (DNS/SDC/ MDS nurses/ RN supervisor) will review the safety device log, the 24 hour nursing report, admission/re-admission assessments, and/or event reports for residents with a fall for initiation, revision, or update of the	

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F 323	Continued From page 19 and "...sensory bed pad alarm..." was added as an update on September 21, 2012. Medical record review revealed the resident had four falls between November 16, 2012, and February 25, 2013 without injury. Continued review of the medical record revealed the resident had a fall on April 4, 2013, and sustained a fracture to the left wrist as a result of the fall. Medical record review of the Post Fall Evaluation form dated November 16, 2012, revealed the resident was found "...sitting on the floor at foot of bed..." Further review of the Post Fall Evaluation revealed, "...Intervention in place at time of fall..." with a checkmark in the box for "alarm". Further review of the Post Fall Evaluation form revealed no documentation the personal alarm or sensory bed alarm were alarming at the time of the resident's fall. Further review of the form revealed, "...Immediate interventions taken to protect resident: was told to ask for assistance..." Review of facility documentation revealed the resident fell on December 18, 2012, in the resident's bathroom, without injury. Continued review of facility documentation revealed intervention in place at the time of the fall was a checkmark in the box for "...alarm..." Continued review of facility documentation revealed no documentation the sensory pad alarm or personal alarm were in place and functioning at the time of the resident's fall. Further review of facility documentation revealed intervention "...Encourage and assist to wear proper nonslip footwear..." Medical record review of the Post Fall Evaluation	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* residents' care plan for appropriate intervention(s) to include documentation and communication to appropriate staff i.e. nursing assistant assignment sheet. A resident with a fall will be referred to the Rehabilitation department for screening if indicated. The interdisciplinary team functioning as the Falls Prevention Committee will meet weekly to review residents with falls in the previous week along with admissions/re-admissions with a fall risk for consistent implementation and effectiveness of the care plan interventions and as indicated revised interventions as well as communicating these revisions to the nursing staff. The DNS/SDC or designee will in-service the nursing staff on the facility on the proper use of safety devices as part of an effective Fall Prevention Program to include a) device in place b) checking device for proper function, c) documentation requirements, d) reporting requirements by nursing staff to supervisors if device defective or missing on 5/13, 5/14, and 5/15/2013. The nursing assistants will check presence and function of safety devices each shift and initial safety device log and notify charge nurse if any device not operating for immediate replacement. The DNS or designee will report the findings	

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F 323	Continued From page 20 form dated February 25, 2013, revealed the resident fell without injury "...resident found on floor in room next to bathroom door...resident states, 'I was coming from bathroom'..." Continued review of the Post Fall Evaluation form revealed, "...Intervention in place at time of fall..." with a checkmark in the box for alarm, and documented in section titled "...Other: (specify) Resident unhooked alarm..." Further review of the form revealed no documentation the sensory pad alarm or personal alarm were functioning at the time of the fall. Continued review of the Post Fall Evaluation revealed, "...Summary of Interdisciplinary Team: Floor Conference with CNA's (Certified Nurse Assistant)/Staff related to making certain alarms are attached and functioning properly-Placing pad alarm back to beds and chairs if they are removed temporarily..." Medical record review of the Post Fall Evaluation form dated April 4, 2013, revealed, "...heard loud noise while standing in hallway. Found pt (patient) lying in floor in RM (room) in front of bathroom door on L (left) side..." Continued review of the Post Fall Evaluation revealed checkmarks in the boxes for alarm, call bell in place, and low bed in the section titled, "...Intervention in place at time of fall..." Further review of the Post Fall Evaluation form revealed no documentation the sensory pad alarm or personal alarm were functioning at the time of the fall. Continued review of the form revealed, "...Summary of Interdisciplinary Team: encourage assisted tolleting q (every) 2 hour-(known to refuse) Bolsters placed on bed to discourage unassisted attempts to get out of bed..."	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* and analysis of the Falls Committee to the Facility Performance Committee at it monthly meeting for review, discussion and recommendations, if any. The Facility Performance Committee met on May 17, 2013 to review and discuss the survey results and to develop and implement corrective action that included F323,	

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F 323	Continued From page 21 Medical record review of the Resident Progress Notes dated April 3, 2013, revealed, "...Pt fell this am (morning)...Roomate reported pt walking to bathroom and tried to open door and lost balance and fell. Landed on left side. Hematoma (collection of blood outside of a blood vessel)...L cheek. Laceration...left side of face...Pt removed bed alarm...sent to (hospital) for evaluation..." Medical record review of the resident's Treatment Record for the month of April, 2013, revealed, "...order date 10/01/2012 sensory bed pad alarm installed d/t (due to) fall risk..." Further review of the resident's Treatment Record revealed no documentation the resident had a personal alarm, and no documentation for monitoring placement or functioning of sensory pad alarm. Medical record review of a Radiology Report dated April 4, 2013, revealed, "...very subtle cortical breaks are present in the distal radius, suspicious for nondisplaced fractures...Conclusion: suspicious for left distal radius fractures..." Medical record review of the Physician's Progress Notes dated April 9, 2013, revealed, "...Had swelling (L) (left) wrist X-ray showed severe osteopenia (low bone density) possible fx (fracture) with 'cortical breaks seen' splint applied..." Continued review of the Physician's Progress Notes dated April 9, 2013, revealed, "... (L) wrist tender Imp (impression) (L) wrist fx..." Medical record review of the resident's care plan updated April 4, 2013, revealed, "...At risk for Musculoskeletal Problems related to Fracture (specify location) Left wrist..."	F 323		

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F 323	Continued From page 22 Interview with Certified Nurse Assistant (CNA) #1 on April 24, 2013, at 1:21 p.m., in the 200 Hallway, confirmed the resident had a history of removing personal alarms. Interview with CNA #2 on April 24, 2013, at 1:25 p.m., in the 200 Hallway, confirmed the resident had a history of removing personal alarms. Interview with Registered Nurse (RN) #1 on April 25, 2013, at 8:25 a.m., in the Nurse's Station, confirmed the RN did not hear alarms sounding at the time of the resident's fall on April 4, 2013. Interview with CNA #2 on April 25, 2013, at 8:33 a.m., in the 200 Hallway, confirmed the CNA was working on on April 4, 2013, at the time of the resident's fall and did not hear alarms sounding at the time of the fall. Interview with the Director of Nursing (DON), and the Staff Development Nurse on April 25, 2013, at 8:00 a.m., in Nursing Administration Office, confirmed the resident had a history of removing personal alarms. Continued interview with the DON and the Staff Development Nurse confirmed there was no documentation the resident's sensory pad alarm or personal alarm were functioning at the time of the resident's falls on November 16, 2012, December 18, 2012, February 25, 2013, and April 4, 2013. Continued interview with the DON and the Staff Development Nurse confirmed the facility was not monitoring the placement or functional status of the resident's sensory pad alarm or personal alarm to prevent falls.	F 323		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=F	Continued From page 23 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F441 The facility has established and maintains an Infection Control Program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Residents #4, #5, #27, #35, and #102 were cohorted and appropriate transmission based precautions that included the appropriate personal protective equipment at each door was initiated. Medical records including the care plan as well as the nursing assistant assignment sheets were updated to reflect the initiated contact precautions. The SDC began in-service with all staff on the facility policy and procedures for Transmission Based Precautions which included contact precautions. During this time period no other residents were identified with an active infection requiring transmission based precautions. The DNS/SDC will conducted additional in-services on the policy and procedures for Transmission Based Precautions to include when and how initiate precautions, notifications requirements, placement of PPE and documentation requirements on 5/13, 5/14, and 5/15/2013. During the weekday clinical rounds conducted by the DNS/SDC/ MDS nurses/ RN supervisor will review the 24 hour	5/18/201

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	445286	A. BUILDING _____ B. WING _____	04/25/2013

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F 441	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation and interview the facility failed to isolate five (#4, #5, #27, #35, #102) of thirty-four residents reviewed with an identified infectious process Methicillin Resistant Staphylococcus Aureus (MRSA). The findings included: Resident #4 was admitted to the facility on September 27, 2008, with diagnoses including Multiple Sclerosis, Multiple Joint Contracture, Chronic Pain, Hypertension, Congestive Heart Disease, Chronic Bronchitis, and Osteomyelitis. Medical record review of a Laboratory Result Form dated March 31, 2013, of a culture obtained from a wound revealed a positive result of MRSA. Medical record review revealed no documentation of the resident being on Contact Isolation. Resident #5 was admitted to the facility on February 13, 2013, with diagnoses including Difficulty in Walking, Urinary Tract Disease and Muscle Weakness. Medical record review of a Laboratory Result Form dated March 9, 2013, of a culture obtained from a rash on the resident's back revealed a positive result of MRSA. Medical record review of a Laboratory Result Form dated April 13, 2013, of a culture obtained from the right eye revealed a positive result of	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* nursing report, admission assessments and lab reports for information/results to ensure appropriate precautions as warranted have been initiated as per the facility's procedures on Transmission Based Precautions. The facility Infection Prevention nurse will track/trend infections that will include the use of and reasons for transmission based precautions, and monitor the staff's compliance with the stated precautions by both medical record review and staff observation. The DNS / Infection Prevention nurse or designee will submit and report on her the findings and analysis of her data collection, observations and audits to the Facility Performance Committee at it monthly meeting for review, discussion and recommendations, if indicated.	

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F 441	Continued From page 25	F 441		

MRSA.

Medical record review revealed no documentation of the resident being on Contact Isolation.

Resident #27 was admitted to the facility on November 16, 2011, with diagnoses including Depressive Disorder, Hypertension, Mitral Valve Disorder, Atrial Fibrillation, and Edema.

Medical record review of a Laboratory Result Form dated April 20, 2013, of a culture obtained from a rash on the resident's back revealed a positive result of MRSA.

Medical record review revealed no documentation of the resident being on Contact Isolation.

Resident #35 was admitted to the facility on November 22, 2010, with diagnoses including Hypertension and Constipation.

Medical record review of a Laboratory Result Form dated April 13, 2013, of a culture obtained from the resident's left eye revealed a positive result of MRSA.

Medical record review revealed no documentation of the resident being on Contact Isolation.

Resident #102 was admitted to the facility on April 10, 2013, with diagnoses including Senile Dementia, Congestive Heart Failure, Altered Mental Status.

Medical record review of a Laboratory Result Form dated April 23, 2013, of a culture obtained from the resident's right eye revealed a positive

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F 441	Continued From page 26 result of MRSA. Medical record review revealed a Resident Progress Note dated March 2, 2013, "...Gentamycin eye treatment continues..." Medical record review of a Resident Progress Note with a Condition Change Form attached dated March 8, 2013, revealed, "...pt (patient) is having yellow color drainage from...eyes..." Medical record review of a Resident Progress Note with a Condition Change Form attached dated April 20, 2013, revealed, "...pt has drainage from both eyes drainage is dark green..." Medical record review revealed no documentation of the resident being on Contact Isolation. Review of the facility policy Disease Specific Information Methicillin Resistant Staphylococcus Aureus (MRSA) dated May 28, 2008, revealed "...Precaution Type Contact...Suggested Supplies For Isolation Cart Gloves Gown...Mode Of Transmission...The main mode of transmission of staph and/or MRSA is via hands, which may become contaminated by contact with...Devices, items, or environmental surfaces contaminated with body fluids containing staph (staphylococcus) or MRSA. Other factors contributing to transmission include skin to skin contact..." Review of the facility's Transmission-Based Precautions dated September 19, 2012, revealed, "...Transmission-Based Precautions are for patients with documented or suspected infection or colonization with highly transmissible or	F 441		

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F 441	Continued From page 27 epidemiologically important pathogens for which additional precautions are needed to prevent transmission...Initiating Transmission-Based Precautions...Place and maintain an adequate supply of appropriate personal protective equipment by the isolation room at the door or use an over-the-door storage system...Contact - Don gloves upon entering room..." Observation of Residents' #4, #5, #27, #35 and #102 rooms on April 23, 2013, at 1:00 p.m., revealed no personal protective equipment at the door and no over the door storage system for personal protective equipment. Interview with the Director of Nursing (DON) on April 23, 2013, at 3:25 p.m., at the nursing station, confirmed the residents were not placed on Contact Isolation and stated "we do universal precautions and hand washing depending where the MRSA is and if it is a draining wound then we contain it, and the resident is allowed to continue going to activities and the dining room." When the DON was questioned about the residents with a diagnosis of MRSA in the eyes, the DON stated "well yeah you know they rub their eyes and we are going to have to make sure they don't touch things out of their room." Further interview with the DON revealed there were five residents with diagnoses of MRSA. The DON stated, "We have five residents with MRSA, two on 100 hall and three on 200 hall. Two have MRSA of the eye (all on 200 hall) one has MRSA of the back (it looks like a rash) and of the eye that resident is also on hall 200. There is one resident on hall 100 with MRSA of the back and one with MRSA on a shoulder wound also on hall 100."	F 441		

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F 441	Continued From page 28 Interview with the Infection Control Nurse on April 24, 2013, at 8:10 a.m., in the Infection Control Nurse's office, confirmed there was not any personal protective equipment at the doorways of the rooms and there was not any documentation of the contact isolation in place in the resident's medical records.	F 441		